STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES
METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN, ARE DESCRIBED AS FOLLOWS:

Citation: MEDICAL AND REMEDIAL
42 CFR CARE AND SERVICES
447 Subpart D. **Item 12.a. (Continued)**

Anti-coagulants	Cardiovascular Drugs including:	Ferrous Sulfate
Anti-convulsants	Diuretics	Folic Acid
Anti-diabetics (Oral)	Antihypertensives	Nicotinic Acid
Calcium Gluconate	Antihyperlipidemics	Potassium Supplements
Calcium Lactate	Estrogens	Thyroid & Antithyroid drugs
Calcium Phosphate	Ferrous Gluconate	Vitamin A, D, K, & B12 injection

C. For patients in nursing homes, the pharmacist shall bill for a minimum of a month's supply of medication unless the treating physician specifies a smaller quantity for a special medical reason

D. Payment will not be made for narcotics prescribed only for narcotic addiction.

E. Enrollees shall have free choice of pharmacy unless subject to the agency's "lock-in" procedures.

F. Vendor payments will not be made for medications which are included under another service (In-patient Hospital, LTC, etc.). The provisions applicable to such service plans shall apply during the time the service is provided.

G. Payment will be made for prescriptions refilled not more than five times or more than six months after issue date and only to the extent indicated by the prescriber on the original prescription, and is restricted by; state and federal statutes. The prescriber is required to state on the prescription the number of times it may be refilled.

H. Prescriptions shall be filled within six months if the date prescribed by a physician or other service practitioner covered under Medicaid of Louisiana. Schedule II narcotic analgesics shall be filled within five days of the date prescribed by a physician or other service practitioner covered under Medicaid of Louisiana. Transfer of a prescription from one pharmacy to another is allowed if less than six months have passed since the date prescribed, and in accordance with the Louisiana Board of Pharmacy regulations.

I. A prescriber who has a suboffice in an area more than five miles from a pharmacy or other facility dispensing medications shall not be paid for medication dispensed, if the main office is within five miles of a pharmacy or other facility dispensing medications.

J. When a prescriber bills Medicaid of Louisiana for medications dispensed, he shall certify that he himself, another authorized prescriber, or pharmacist dispensed the medications and he shall maintain the same records as required of an enrolled pharmacy provider.

STATE Louisiana
DATE REC'D FEB 14 1992
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42 CFR CARE AND SERVICES
447 Subpart D. **Item 12.a. (Continued)**

K. The manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is purchased by a provider. Drug products supplied through repackaging into smaller quantities by chain drug store central purchasing shall be billed by the dispensing pharmacy using the manufacturer number, product number, and package size number of the package size purchased by the central purchasing unit. If the package size is larger than the largest size listed by Medicaid of Louisiana, then the package size billed shall be the largest size listed in the American Druggist Blue Book or other national compendia used by the state to update the Medicaid Management Information System. In instances where drugs are supplied in smaller quantities by a manufacturer or third party under a special purchase arrangement, contract, or agreement not generally available to all providers; then the package size billed shall be the largest size listed in the American Druggist Blue Book or other national compendia utilized to update the Medicaid Management Information System.

V. ESTABLISHMENT OF MAXIMUM ALLOWABLE OVERHEAD COST

Limits on overhead cost are established through the overhead cost survey process which classifies cost in accordance with generally accepted accounting principals (GAAP) and Medicare principles (Provider Reimbursement Manual HIM-15) regarding the allowability of cost.

STATE Louisiana
DATE REC'D FEB 14 1992
DATE APPV'D JUL 02 1992
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HCFA 179 92-01
A

A. Definitions

1. Adjustment Factors
   CPI-All Item Factor
   CPI-Medical Care Factor
   Wage Factor

   Each of the above adjustment factors is computed by dividing the value of the corresponding index for December of the year preceding the overhead year and by the value of the index one year earlier (December of the second preceding year).

   ROI - Return On Investment - One year treasury bill rate applied to a portion of prescription drug cost (17%) in recognition of inventories maintained for the purpose of filing prescriptions. The percentage recognized as a continuing inventory cost is based upon replacement of dispensing stock at least six times per year resulting in an average inventory investment equal to 1/6th of prescriptions filled.

2. Base Rate - means the rate calculated in accordance with section B., plus any base rate adjustments granted in accordance with section E.(2) which are in effect at the time of calculation of new rates or adjustments. The base rate was initially calculated using the SFY 90/91 pharmacy survey findings of average cost for pharmacies representative of the average pharmacy participating in Medicaid of Louisiana (15,000 - 50,000 Rx volume). This rate was then inflated forward to December 1990 to establish the first overhead cost maximum.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

CITATION
42 CFR 447
Subpart D

MEDICAL AND REMEDIAL CARE AND SERVICES
Item 12.a. (Contd.)

3. Base Rate Components- The base rate is the summation of the components shown below. Each component is intended to set the maximum allowable for the costs indicated by its name.

Overhead Cost Component	Adjustment Factors Applied
Pharmacist Salaries	CPI - Medical Care
Other Salaries	Wage
Other Routine Services	CPI - All Items
Inventory Cost	ROI - (1) No Return on Equity allowed
Fixed Cost	None - (2) No Return on Equity allowed
Return on Equity	None - (3) Adjusted by ROE Factor

4. Indices

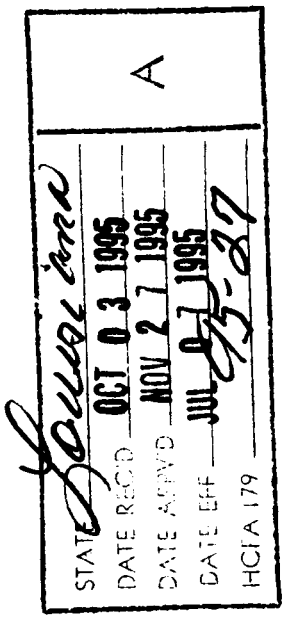
CPI - All Items - The Consumer Price Index for all Urban Consumers - Southern Region - All Items Line as published by the U.S. Department of Labor.

CPI-Medical Care - The Consumer Price Index for all Urban Consumers - Southern Region - Medical Care Line as published by the U.S. Department of Labor.

Wage - The average annual wage for production or non-supervisory service workers as furnished by the Dallas Regional Office of the Bureau of Labor Statistics of the U.S. Department of Labor.

ROI - Interest Rates - Money and Capital Markets - The average percent per year for one year U.S. Treasury bills taken from the Federal Reserve Bulletin report on Money Market Rates for the 1993 calendar year.

5. Maximum Allowable Overhead Cost - Overhead cost determined through use of cost survey results adjusted by various indices to assure recognition of costs which must be incurred by efficiently and economically operated providers. The cost determined is referred to as a maximum allowable to reflect application of the "lessor of" methodology for determining total reimbursement.



STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

CITATION
42 CFR 447
Subpart D

MEDICAL AND REMEDIAL CARE AND SERVICES
Item 12.a. (Contd.)

6. Overhead Year - The one year period from July 1 through June 30 of the 1993 calendar year. It corresponds to a State Fiscal Year.

B. Calculation of Maximum Allowable Overhead Cost

1. The 1994 cost survey results will be utilized to establish base cost for: Professional salaries; Other salaries: Other routine costs; and Fixed cost. Claims processing data for claims paid in the current overhead period will be utilized to determine average drug cost. Seventeen percent (17%) of this cost was utilized as base prescription inventory required for Medicaid participation. The base prescription inventory amount shall not be added to the overhead cost maximum allowable. Base prescription inventory is recognized as an allowable investment subject to a return on investment only. Calculation of maximum allowable overhead cost per prescription shall be performed as follows:

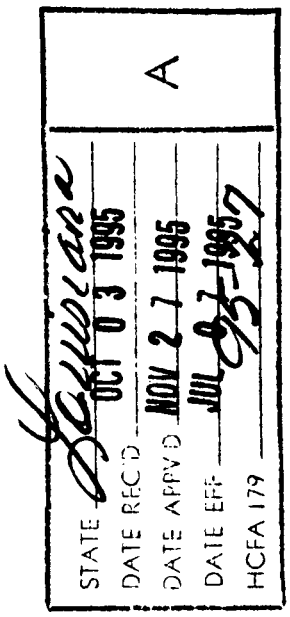
NORC = ORC X CPIAI
NORC is the new other routine cost component
ORC is the current (base) routine cost component
CPIAI is the CPI - All Items Adjustment Factor

NPS = PS X CPIMC
NPS is the new pharmacist salaries cost component
PS is the current pharmacist salaries cost component
CPIMC is the CPI - Medical Care Adjustment Factor

NOS = OS X W
NOS is the new other salaries cost component
OS is the current salaries cost component
W is the Wage Economic Adjustment Factor

NROI = ROI X IR
NROI is the new return on investment component
ROI is 17% of the current average drug cost taken from Medicaid claims data
IR is the Interest Rate - Money & Capital Markets

RATE = (NORC + NPS + NOS + FCC) X ROEF + NROI
NORC, NPS, NOS and NROI are computed by the formulae above.



CITATION
42 CFR 447
Subpart D

MEDICAL AND REMEDIAL CARE AND SERVICES
Item 12.a. (cont'd.)

FCC is the fixed cost component which does not include prescription drug inventory. ROEF is the return on equity factor of 1.05 applied to all cost components except return on investment which is calculated separately.

After formal adoption of the first maximum allowable overhead cost limit, based upon the most recent overhead cost survey, the components computed above will become the base components used in calculating the next year's overhead maximum allowable effective for July 1, unless they are adjusted as provided in E below.

C. Parameters And Limitations

All calculations described herein shall be carried out algebraically. In all calculations the base maximum allowable and the base components will be rounded to the nearest one (1) cent (no less than two decimal places) and the Economic Adjustment Factors will be rounded to no less than four (4) decimal places. No downward adjustment in the maximum allowable overhead rate shall be made in violation of §1927(f)(1)(B).

The dispensing fee in effect and protected during the mandatory moratorium period shall be the lowest maximum allowable overhead rate which may be established by the Bureau of Health Services Financing during the moratorium period.

D. Cost Survey

Every three years a cost survey shall be conducted which includes cost data for all enrolled pharmacy providers. Participation shall be mandatory for continued enrollment as a provider. Cost data from providers who have less than 12 months of operating data shall not be utilized in determining average overhead cost or grouping providers by prescription volume. Predesk reviews shall be performed on all cost surveys to determine an average provider profile based upon total prescription volume. Through statistical analysis, minimum and maximum volume ranges shall be established which represent the majority of providers participating in Medicaid reimbursement. Cost data from providers whose prescription volume is above or below the volume range established shall not be utilized in calculating average overhead cost.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

CITATION
42 CFR 447
Subpart D

MEDICAL AND REMEDIAL CARE AND SERVICES
Item 12.a. (Contd.)

Information submitted by participants shall be desk reviewed for accuracy and completeness. Field examination of a representative sample of participants shall be primarily random, but geographic location and type of operation shall be taken into consideration in order to ensure examination of pharmacies in various areas of the state and representative of various types of operations.

1. Cost Finding Procedures

   The basic analytical rationale used for cost finding procedures shall be that of full costing. Under full costing, all costs associated with a particular operation are summed to find the total cost. The objective of cost finding shall be to estimate the cost of dispensing prescriptions through generally accepted accounting principals (GAAP).

2. Inflation Adjustment

   Where data collected from participating pharmacies represents varying periods of time, cost and price data may be adjusted for the inflation that occurred over the relevant period. The appropriate Consumer Price Index indicator (Table 12, Southern Region, Urban Consumer) and wage indicator produced by the U.S. Department of Labor Statistics shall be utilized.

3. In addition to cost finding procedures, a usual and customary survey shall be included in the survey instrument. This instrument shall be used to determine the following:

   (a) An average usual and customary charge, or gross margin for each pharmacy.

   (b) The computation of the net margin per prescription (gross margin less computed dispensing cost per prescription) in order to approximate the average profit per prescription.

   (c) Computation of the average percentage of markup per prescription.

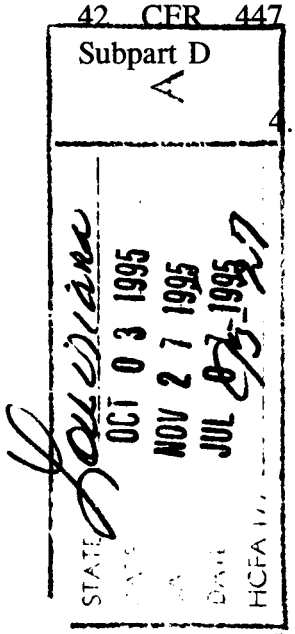
   (d) The computation of average usual and customary charges shall include adjustments to allow comparability with upper limits for prescription reimbursement utilized by the Bureau of Health Services Financing.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

CITATION
42 CFR 447
Subpart D

MEDICAL AND REMEDIAL CARE AND SERVICES
Item 12.a. (Contd.)



4. Statistical Analysis

Statistical analysis shall be undertaken to estimate the cost to pharmacies of dispensing prescriptions. Such analysis shall include, but not be limited to:

(a) An average dispensing cost of pharmacies.

(b) Analysis of the correlations among overhead costs and parameters deemed relevant to pharmacy cost.

(c) The statistical relationship between independent variables and the cost to dispense prescriptions shall be analyzed using the techniques of simple linear and stepwise regression. Independent variables may include annual volume of prescriptions filled, pharmacy location, type of ownership, and number of Medicaid claims paid.

5. Survey Results

The Bureau of Health Service Financing shall consider survey results in determining whether the maximum allowable overhead cost should be rebased. Where the overhead cost survey findings demonstrate the current maximum allowable is below average cost or above the 80th percentile of cost, rebasing shall be required. The Bureau may review the survey data and establish a new overhead cost utilizing the cost survey findings and any other pertinent factors, including but not limited to: inflation adjustment; application of return on equity; recognition of inventory investment; etc.

E. Interim Adjustment to Overhead Cost

If an unanticipated change in conditions occurs which affects the overhead costs of at least fifty percent(50%) of the enrolled provider by an average of five (5%) per cent or more, the maximum allowable overhead cost may be adjusted. The Bureau determine whether or not the maximum allowable overhead cost limit should be changed when requested to do so by at least ten (10%) per cent of the enrolled pharmacies. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. The Bureau, however, may initiate an adjustment without a request to do so. Changes to overhead cost may be one of two types:

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

CITATION
42 CFR 447
Subpart D

MEDICAL AND REMEDIAL CARE AND SERVICES
Item 12.a. (cont'd.)

1. Temporary Adjustments

Temporary adjustments do not affect the base cost used to calculate a new maximum allowable overhead cost limit. Temporary adjustments may be made in the rate when changes which will eventually be reflected in the Economic Indices, such as a change in the minimum wage, occur after the end of the period covered by the index, i.e., after the December preceding the limit calculation. Temporary adjustments are effective only until the next overhead cost limit calculation which uses Economic Adjustment Factors based on index values computed after the change causing the adjustment.

2. Base Rate Adjustments

Base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the Indices. This would normally be a change in service requirements. Base rate adjustment will result in a new base rate component value(s) which will be used to calculate the maximum allowable overhead cost for the next year.

F. Effective July 1, 1995 and thereafter, the Maximum Allowable Overhead Cost will remain at the level established for state fiscal year 1994-95.

STATE Louisiana DATE REC'D 9-3-98 DATE APP'D 11-13-98 DATE EFF July 1, 98 HCFA ID 98-014	A

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION	MEDICAL AND REMEDIAL CARE AND SERVICES
42 CFR 450.30	Item 12b. Dentures

I. Methods of Payment

Adult denture services are reimbursed the lower of the dentist's billed charges or the state established schedule of fees. The established fee schedule does not exceed the median statewide denture charges for the identified procedure. This fee schedule is reviewed annually.

II. Standards for Payment

Only the services of dentists who are licensed by the State Board of Dental Examiners are reimbursed.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM, UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION		
42 CFR 447.304	Medical and Remedial Care and Services Item 12c	Prosthetic Devices (including artificial eyes, braces, and other prosthetic devices) as well as medical appliances, equipment and supplies)

I. Methods of Payment - Reimbursement for durable medical equipment is determined by a dual methodology.

OPTIONAL FORM 99 (7-90)
FAX TRANSMITTAL
To Josie Cruser
Dept./Agency
Fax # 504-342-3893
From Linda
Phone # 767-3693
# of pages ▶ 3
NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

Some durable medical equipment including prosthetic and orthotics will be reimbursed at a flat fee or according to the billed charges, whichever is the lesser amount. These are standard items which are uniform in nature.

The flat fee components of the reimbursement methodology are established:

1. utilizing 80% of the Medicare DME fee schedule or at the lowest cost at which a needed item has been determined to be widely available by analyzing usual and customary fees charged in a community

   OR, if the item is not available at 80% of the Medicare fee schedule,

2. the flat fee to be utilized will be 100% of the Medicare DME fee schedule or at the lowest cost at which these items have been determined to be widely available by analyzing usual and customary fees charged in a community.

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B. Another group of equipment is priced on an individual basis. Pricing of this equipment group is based on an item-by-item analysis due to the unique specifications of each item and the beneficiary's